STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 92896-001-SF**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 20th day of November 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 26, 2008, XXXXX, on behalf of her minor daughter XXXXX ("Petitioner"), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The initial request was incomplete. After additional information was provided, The Commissioner accepted the request on September 19, 2008.

Under section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross Blue Shield of Michigan ("BCBSM") of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 26, 2008.

The Petitioner receives health care benefits through the State of Michigan employees PPO

Plan, a self-funded group. BCBSM administers the plan. Benefits are defined in the State Health Plan Benefit Guide. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

Petitioner has a medical condition which requires the use of a nebulizer for delivery of medication. On April 25, 2007, XXXXX purchased for her daughter a nebulizer with compressor and aerosol mask from Vital Care Home Medical Equipment, an out-of-network (nonparticipating) provider. The cost of these items was $228.49. The device is considered durable medical equipment, or "DME".. The coverage for DME is described in the Benefit Guide. BCBSM's approved amount for this care was $60.73. BCBSM applied a 20% deductible and paid $48.58 to the Petitioner. This left a balance of $179.91 for the Petitioner to pay.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on July 23, 2008, and issued a final adverse determination dated August 1, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's nebulizer with compressor and the aerosol mask?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's mother says she was sent to Vital Care to purchase home medical equipment for her daughter. Vital Care ran her insurance card and told her that BCBSM would cover this equipment. A year or more later she was billed by Vital Care for the equipment provided her daughter.

The Petitioner's mother says she was told that she was using a BCBSM provider. She believes that BCBSM should be required to pay substantially more for her daughter's medical

equipment.

BCBSM's Argument

BCBSM says that the Benefit Guide clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is defined as the lesser of the provider's charge or BCBSM's maximum payment level for the service. The Benefit Guide does not guarantee that charges will be paid in full. Moreover, since the medical supplier in this case does not participate with BCBSM, it is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between its charge and BCBSM's payment.

BCBSM says that since the medical supplier is not part of the PPO network the approved amount for the nebulizer with compressor and the aerosol mask was subject to a 20% copayment.

BCBSM says that it has paid its approved amount minus a 20% copayment or $48.58 to the Petitioner for her nebulizer with compressor and the aerosol mask. BCBSM contends that it has paid the proper amount for the Petitioner's care and is not required to pay more.

Commissioner's Review

The medical supplier that provided the Petitioner's medical equipment is a nonparticipating provider. Under the Benefit Guide, BCBSM pays an "approved amount" for covered services – it does not guarantee that provider charges will be paid in full. "Approved amount" is defined in the Guide on page 80 as "the BCBSM maximum level or the provider's charge for the covered service, whichever is lower." The only difference between the amount paid for services from participating and nonparticipating providers is a 20% copayment for nonparticipating providers since they are not part of the PPO network.

The amount charged by any provider may be significantly higher than BCBSM's payment level for the service. However, participating providers must accept BCBSM's approved amount as payment in full, regardless of the charge. Nonparticipating providers are free to demand payment up to their entire charge. Since nonparticipating providers have not signed agreements with

BCBSM to accept its approved amount as payment in full, the Petitioner, as the guide explains on page 17, "may also be responsible for any charge above BCBSM's approved amount."

The Petitioner did not use a participating provider, apparently because the nonparticipating medical supplier that furnished the nebulizer with compressor and aerosol mask was recommended to her. Nevertheless, there is nothing in the Benefit Guide that requires BCBSM to pay more than its approved amount (minus a 20% copayment) for services or items from a nonparticipating provider, even if a participating provider was not available. The Petitioner remains responsible for the difference between BCBSM's payment and the provider's charge.

V
ORDER

BCBSM's final adverse determination of August 1, 2008, is upheld. BCBSM is not required to pay any additional amount for the medical equipment purchased for the Petitioner on April 25, 2007.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.